

# ST. BARTHOLOMEW'S



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### DOWN THE DRAIN

For some years past this country has been warned that, at the present birth-rate, after three or four more generations the population will number no more than a mere ten millions and that a large proportion of society at that time will be too old to work. Thereafter the population will remain steady, numbering some few millions, and Britain will be but a puny nation. The Prime Minister has remarked that had not the population risen in Victorian days synchronous with the country's rise of power, "we might have gone down the drain with many other minor states." We are now faced with a similar fate. It would indeed be ignominious to have battled to victory, to have taken our place in whatever New World finally emerges from the brains of the Allied Statesmen, and then to sink into insignificance after so total a war-effort.

Numbers, though, do not mean everything; civilisation does not only advance through the efforts of the multitude. Throughout history small nations have contributed as much as large nations; our debt to insolent Greece is greater than that to mighty Persia. By becoming a small nation we may not lose our place in the hierarchy of nations, but only if a small community is allowed to thrive in peace. A handful of millions will have little say in helping to carry out the clauses of the Atlantic Charter. Are we to become a great industrial trading nation on whom the advance of civilisation will depend, or are we to allow ourselves to degenerate into the senile agricultural minority of the statisticians' prophecies? The answer depends upon our fertility.

There is at present a paradox in this matter. The Registrar-General has recorded an increase of 68,000 in the birth-rate of 1942 over that of 1941, and the highest birth-rate since 1928.

The number of marriages has also increased during the war years, an increase comparable to that of the post-war years of 1919 and 1920. At the present, owing to these increases and because of the shortage of midwives and nurses, there is great difficulty in providing beds for confinement. All this would give the appearance that the ominous prophecies are being avoided. But the reversal of the fall in the birth-rate does not absolutely depend on the increase of marriages, but on an increase in the number of children in each family, and the Return of the Registrar-General does not warrant any such assumption.

An increase in the number of a family cannot be brought about in a democracy simply by an order, or by bribery. People will not have more children just for an extra few shillings a week. It needs a change of opinion, a knowledge of the need for Britain to be great in order to bring about such an increase. The disadvantages of having large families must then be removed, family allowances must be granted, adequate for subsistence and education. Most important, as can be realised from present conditions, is the provision of medical service to safeguard maternity and childhood, and the means with which the extra costs of child-bearing can be met. Housing, from the point of view of healthy public life, and in the best situation for nurturing the future generations, is a consideration in which the medical profession has no small say. As the various schemes for the New Britain take shape the responsibility of Medicine for their evolution becomes wider and of fundamental importance; should we go down the drain the medical profession will not be free from incrimination for the disaster.

## A CASE OF TRIAL LABOUR PRESENTING SOME UNUSUAL FEATURES

By R. W. LAMBERT HURT

One of the functions of an antenatal clinic is to anticipate and prevent the occurrence of obstructed labour. If on antenatal examination there is doubt as to whether it is possible for delivery to take place per vias naturales, the patient is admitted into hospital for what is called trial labour, with a view to subsequent delivery by Cæsarean Section if necessary.

In the case to be described, trial labour was proposed on account of what appeared to be a low uterine fibroid. Subsequent investigation, however, showed Cæsarean Section to be contra-indicated.

### CASE HISTORY

Mrs. A.B., a primigravida aged 29 years, was admitted to St. Bartholomew's Hospital for trial labour on November 12th, 1942. During routine examination at an antenatal clinic in the 38th week of the pregnancy, a firm swelling, about 2 inches in diameter and situated at the posterior part of the lower uterine segment, had been felt per vaginam. A tentative diagnosis of a low uterine fibroid (which might cause obstruction) had been made. Up to this time, the pregnancy was progressing normally. Foetal movements were first felt during the 19th week, and the urine and blood pressure were normal.

Apart from rheumatic fever at the age of 12 years, the patient had always been in good health. Her menstrual history was normal.

At the time of examination, she looked healthy, and the mucous membranes were a good colour. There was some tonsillar sepsis, with enlarged glands on both sides of the neck. Examination of her heart showed a well compensated mitral stenosis, and the lungs were normal. The breasts were poorly developed, the areola was pink, and Montgomery's tubercles were present.

The uterus was enlarged to the size of a 38 weeks' pregnancy, corresponding to the date of the last regular period. There was some doubt as to the position of the fœtus, but it was thought to be a vertex presentation, with the head well engaged in the pelvis. The foetal heart was easily heard below the umbilicus, both to the right and left of the mid-line. The pelvic swelling could not now be felt, either per abdomen or per rectum, nor was there any tenderness. The abdominal circumference was normal.

Plain X-ray of the abdomen showed a breach presentation with extended legs. In addition, in the antero-posterior view, the foetal skull appeared to be enlarged, whilst in the lateral view there was a lack of continuity of the bony margin of the skull in the region of the lambda, which appeared to be widely open. Allowing for distortion, the bi-parietal diameter was  $4\frac{1}{2}$  inches. On re-examining the patient in the light of the X-ray findings, the foetal head felt larger than normal. No "egg-shell crackling" sensation could be elicited.

In view of the X-ray appearances, it was thought that the fœtus was almost certainly hydrocephalic, and so should not be delivered by Cæsarean Section. Accordingly, labour was induced medically. In order to sensitize the uterus to pitocin, 5 mgms. of stilbœstrol were given orally, and repeated after 20 hours. Ol. Ric.  $1\frac{1}{2}$  oz. was given 5 hours after the second dose of stilbœstrol, followed in 1 hour by 2 units of pitocin. The pitocin was repeated hourly five times. After the third pitocin injection, a soap and water enema and hot bath (103°F.) were given.

Labour did not commence till the 28th November, three days after the conclusion of the medical induction. The first stage lasted 48 hours, and at 3 p.m. on the 30th November, the cervix was fully dilated. The foetal heart, which previously had been beating regularly at 140/minute, could no longer be heard 24 hours after the commencement of the first stage. At 3.30 p.m., the membranes ruptured spontaneously, and the breech was just visible at the vulva.

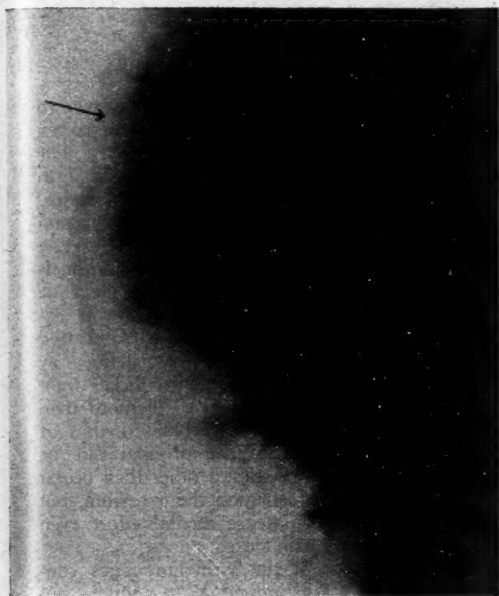
Delivery under G.O.E. anaesthesia was begun at 4.30 p.m. by Mr. D. B. Fraser, as natural delivery had made no progress for an hour. The fœtus was in the R.S.A. position. The anterior and then the posterior legs were brought down; they both showed signs of maceration. The body was then successfully delivered by traction on the legs, revealing the presence of spina bifida and ectopia vesicæ. In order to deliver the enlarged head, cerebral decompression was necessary. By making use of the myelocœle, a metal catheter was passed up through the vertebral canal into the cranium, and through this catheter about 7 ozs. of cerebro-spinal fluid and brain material were withdrawn. The delivery was then completed. A small first degree tear was repaired, and the placenta delivered after 15 minutes by a Crêdè expression. The uterus contracted well, and 0.5 mgm. of ergometrine was given intramuscularly.

The puerperium was uneventful. During the first two days, 0.5 mgm. of ergometrine was given orally b.d., as there was an excessive amount of blood in the lochia. On the eleventh day, the lochia ceased altogether. On the first day the fundus was 5 inches above the symphysis. Involution proceeded rapidly, and by the seventh day the fundus was one inch above the symphysis, at which level it remained till her discharge on the fifteenth day. No tumour was palpable per abdomen. To inhibit milk formation, the breasts were compressed with a tight bandage, and 0.5 mgm. of stilbœstrol was given b.d. for three days.

No postnatal vaginal examination was performed in Hospital, but eight weeks after discharge, it was found that the uterus was well involuted. Furthermore, no fibroid or other pelvic abnormality was present.

### DISCUSSION

Although fibroids may be causally associated with sterility, it is by no means uncommon to find symptomless fibroids, multiple or single,



*Lateral view, showing the open posterior fontanelle.*

complicating a pregnancy, and this was thought to be the condition in this case. The pregnancy having already reached the 38th week, the subsequent course of the labour depended on whether the tumour would rise out of the pelvis before the second stage of labour commenced, or remain in the pelvic cavity, and cause an obstruction in the birth canal. In the former case, delivery might or might not progress normally, whereas in the latter, delivery by Cæsarean Section would be inevitable.

When admitted to hospital, the pregnancy was at term. No tumour could be felt per abdomen or per rectum, and the breech was well engaged in the pelvis. Thus the tumour had risen out of the pelvis, and was situated in close proximity to the lumbar vertebral bodies; it would probably cause no difficulty in natural delivery. As the possibility of Cæsarean Section still existed, a plain X-ray of the abdomen was taken. On the film, the skull

outline suggested hydrocephalus—the abnormal width of the fetal head and the widely open posterior fontanelle. Thus it was concluded that the fetus was hydrocephalic to such a degree as to be incompatible with life. It followed that delivery by Cæsarean Section was not justifiable. Moreover, the fetal heart was no longer heard after the 29th November, soon after labour commenced.

The method of cranial decompression also deserves mention. Perforation of the skull through the occiput in the usual manner may cause jagged ends of bone to protrude, and lead to cervical or perineal laceration. In this case, the presence of a low dorsal myelocœle allowed a metal catheter to be passed with great ease through the vertebral canal, and into the cranium. By this means the cerebro-spinal fluid was rapidly withdrawn, allowing a great reduction in the size of the skull, and at the same time preserving intact the skin over the cranial bones. Blockage of the catheter was prevented by the periodic use of a thin metal bougie.

It is interesting to note that although one of the commonest causes of hydramnios is some fetal abnormality, in the case described there was no evidence of this, in spite of gross fetal maldevelopment.

As no sign of a fibroid was found on pelvic examination eight weeks after delivery, it is considered that the tumour originally felt per vaginam was a tense lutein cyst.

#### SUMMARY

A case is described in which a trial labour was proposed on account of a pelvic tumour—at the time thought to be a fibroid.

In all cases in which Cæsarean Section is being considered, the importance of a plain X-ray to exclude gross fetal abnormality is emphasised. In this case, hydrocephalus was shown, and delivery by Cæsarean Section therefore contra-indicated.

Cerebral decompression of hydrocephalus by a catheter through a low dorsal myelocœle was performed as an aid to natural delivery.

I should like to express my thanks to Mr. Fraser for permission to publish this case, and for his help and encouragement in the preparation of the paper; also to Dr. Yorke for the use of the X-rays.

## ABERNETHIAN SOCIETY

A meeting of the Abernethian Society was held in Bart.'s on Thursday, March 18th, when Professor E. D. Adrian, O.M., addressed the Society on "The Electroencephalograph."

Professor Adrian prefaced his lecture by remarking that he had spoken to the Society once before, during the last war. On that occasion he had discussed the vitamins, whose existence was then almost unknown except to a small band of workers, including, of course, the famous Hopkins. He recalled how Hopkins worked in a cellar next his own, and how ubiquitous and overpowering was the odour of Hopkins' rats. He had ventured in that lecture to make some prognostications about the future importance of the vitamins, which had been more than fulfilled, and he hoped that he would be equally fortunate in any predictions he might make about the subject of his present lecture. In regard to the future, he felt one of the most promising fields of activity for the electroencephalograph lay in the direction of the determination of personality types.

The development of the E.E.G. was primarily due to the work of Hans Buerger, who was head of a mental hospital in Jena, during the years 1924-34. Although Buerger published his work in a reputable journal, he did not possess the ability, or inclination, to summarise and publicise adequately, with the result that his work remained for long unnoticed and unrecognised. Professor Adrian here took the opportunity of drawing attention, through this outstanding example, firstly to the desirability of scientists acquiring the technique of effective presentation, and secondly, to the need for better liaison between scientific workers in various fields of activity. Buerger had, in fact, discovered most of the known fundamental facts of electroencephalography, including such things as the existence of characteristic waves in epilepsy and cerebral tumour.

The normal basic  $\alpha$ -rhythm, now known by his name, consists of a succession of waves about  $\frac{1}{2}$ -millivolt in potential and having a frequency in the region of 10 per second. This rhythm can only be obtained when the subject is at rest with his eyes closed and is abolished by mental tension or strain, for instance, during the performance of rapid mental arithmetic. It has been shown to arise in the cerebral cortex, and the implication of the phenomenon is that large groups of nerve cells are pulsating

in electrical unison. The rhythm is believed to appear only when considerable areas of cortex are disengaged from normal activity. The potential change of the waves is maximal in the occipital and parietal regions in the majority of individuals, although in some the frontal area gives rise to large waves. The largest waves of all have been obtained from animals in which the brain is exposed and an electrode applied direct to the striate area; in this experiment a light shone on the eye destroyed rhythm. In the case of human beings, by causing the entire visual field to flicker light and dark alternately at a rate of more than 10 times per second, a new basic rhythm of greater frequency than the original can be established. Sensory stimuli other than ocular have much less effect upon the  $\alpha$ -rhythm, but it is destroyed by intense mental effort even when the eyes remain closed.

The character of the  $\alpha$ -rhythm varies considerably from one individual to another, but is remarkably constant for any given subject. In one-third of people it is poorly defined. Many attempts have been made to correlate different varieties of  $\alpha$ -rhythm with different mental attributes, but with conspicuous lack of success—as Professor Adrian emphasised, in remarking on some of the doubtful qualities with which his own electroencephalogram had been associated!

On the whole, variations in frequency give more definite information than fluctuations in potential. Slow waves are normal in infants, during very deep sleep (delta waves) during hyperventilation, and in anaesthesia. A reduction in frequency is also observed in cerebral contusion, coma, and recovery from epileptic fits. A slow rhythm is only found locally in locally unfavourable conditions, for example, in the area surrounding a cerebral tumour (over the tumour itself electrical changes are entirely absent). This, of course, is the basis of the use of the E.E.G. in the localisation of intracranial neoplasm. This is now one of the most important applications of the instrument, and it has in fact largely superseded the technique of encephalography and ventriculography, even in the clinic of Danby, who originated the latter methods.

The other great clinical application of the E.E.G. is in the diagnosis of epilepsy. During attacks, the electroencephalogram exhibits characteristic wave forms (tall spikes and



rounded crests) and frequency changes, those of grand mal being quite distinct from those of petit mal, and all these again being clearly differentiated from the d-wave form. It is a most interesting fact that alterations in the electroencephalogram can be shown to precede the development of the aura in grand mal attacks. In between attacks, too, there are typical abnormalities in the tracing; these may take the form of large slow waves superimposed upon the normal  $\alpha$ -rhythm. These irregularities, when absent, may be brought out by hyperventilation, and may be destroyed by causing the patient to do mental work. Eighty per cent. of epileptics exhibit such abnormalities, but they may, on the other hand, also be shown by subjects who never have epileptic attacks. It is, moreover, possible to localise the area of the brain in which the attacks originate, although developments along this line have not proved of such value as might have been anticipated.

Finally, it is to be hoped that the E.E.G. may

become of use in determining the efficiency of the brain; Professor Adrian said he believed the future held considerable possibilities in this connection. The difficulty, however, lies in recording waves from a part of the brain when that part is actually in action. It is interesting to note that of a group of air-pilots who had passed exacting flying tests, only 5 per cent. had an abnormal electroencephalogram, while 15 per cent. of a control group and 26 per cent. of a group of psychopaths showed similar abnormalities. Nevertheless, to be of real value, the E.E.G. had to be elaborated into an instrument capable of showing more than a mere epileptoid tendency in individuals exhibiting no gross aberration of personality.

The lecture was illustrated with a number of lantern slides.

After Professor Adrian had answered a number of questions, a vote of thanks was proposed by Dr. Hinds-Howell.

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## MEDICAL ETIQUETTE

I have often wondered why there are no lectures to medical students about medical etiquette; or are there?—I haven't been at Bart.'s since 1909. Knowledge of correct behaviour towards other medical men does not come by the light of Nature, it must come by instruction or be handed down by tradition. If one's father has been a doctor one imbibes the idea of behaviour from early years, but if no one of one's family has been a doctor one must learn it as an assistant, now that apprenticeship is no more, and if one has never been an assistant it is difficult to see how it can be learned. Probably it is not learned, which accounts for the purely commercial line taken by many younger men in their practices. There is no etiquette among tradesmen. The only example I ever heard of, of such a thing, was when I read in Cranford how Miss Matty, when she entered into commerce, was only persuaded at last to sell tea after convincing herself that she would not offend the Cranford grocer, Mr. Johnson, by competing with him.

Medical etiquette is purely between one man and another, not between a doctor and the public. Medical ethics is a much wider term, including medical etiquette but extending to a doctor's relations with patients and the public. It includes the code of behaviour laid down in the Hippocratic oath. Breach of

ethics means breach of good behaviour; breach of etiquette means bad behaviour, boorishness, not bothering to write to a colleague about a patient of his you have treated in an emergency, or taking over a patient in the course of an illness without the patient's doctor's knowledge. Incredible to think that can happen, but it often does; or in war time, the complete ignoring of civilian medical men by the Army medical machine, as happens also.

Patients don't know anything about medical etiquette or ethics and generally think they can call in anyone just as they change their tradesman, but they would not do so if doctors themselves were particular. Free choice of doctor is always one of the chief points made and insisted upon by speakers at meetings where medical reform is discussed, but patients should not be allowed to chop and change at will without cause as they so often do, and as they are so often encouraged to do by competing doctors.

The public scoff at the word *etiquette* as regards medical methods. They think we are a close corporation, hand in glove with each other, and most jealous of each other's welfare, which we are certainly not. If we were we should be consulted by the Government a good deal more than we are, because we should be a very powerful body of men, instead of a very

weak one. When patients say, as they often do, "I don't care a hang for medical etiquette," the proper reply is, "But I do."

I can find little reference to the necessity of decent ethical behaviour between medical men in the Hippocratic oath, nearly all reference is to our behaviour to our patients. We are not taught in our young days how to behave to each other, but only to the public. I don't know if there is intense rivalry and even bitterness in legal circles, but among a number of doctors in a town there is much of both and even among partners in a firm of many doctors. A few first hints and talks to men in hospital before they are qualified would do much to lessen this, and I have never been able to understand why this branch of instruction is utterly neglected. The lecture should be repeated often, and there is no doubt it would be well attended if given by a shrewd and kindly physician of experience and understanding.

I remember with pleasure attending an operation on a patient with Sir St. Clair Thomson, a difficult and rather unsatisfactory case. We walked down the street afterwards and he gravely observed that "at any rate we have obeyed an important Hippocratic precept. We have done no harm." It is no doubt very important to do no harm, but it is equally important to do no harm to a brother medical man. One of the details of medical etiquette is that the practitioner precedes the consultant up the stairs to the patient's room, and ushers him out of the room before him. This is to prevent any hint or possibility of the consultant having a private word with the patient, unbeknown to the practitioner—a dreadful comment on medical suspicion. As a matter of fact I did once hear of a consultant from London dodging back to whisper that the patient had got the wrong doctor, it should have been Dr. — of the same town. He was a very eminent consultant indeed, but he had a poor reputation for good behaviour to humbler doctors.

My uncle sent a patient by train to see a physician in London who informed the patient that he ought never to have been allowed to travel, which damned my uncle in the patient's and his relatives' eyes for ever.

Perhaps after all, a course of lectures would have little effect on men who don't really know how to behave, but it would induce the majority of students to understand they were not in the same position as rival sellers of tea or motor-cars.

Medical ethics and etiquette are based on the Hippocratic oath. The modern doctor refuses to shorten life, to cause abortion, and to divulge

information committed to his honour, and he still attends the families of his fellow practitioners without fee.

Gross breaches of etiquette and ethics sometimes approach the ludicrous. I can vouch for the following:—

1. A doctor engaged to attend a midwifery case visits and examines the patient in labour, explains that all is well and leaves, saying he will return soon. When he returns he finds the patient's husband has called in another doctor who has applied forceps and delivered the child.
2. A. was called to a woman, a stranger, with follicular tonsilitis, and called again in two days when he was informed that Dr. B. had been called in meanwhile who said it wasn't tonsilitis (although it was) and was coming again tomorrow. Exit A.
3. A timid lady patient was being attended by a doctor for some obscure trouble, who, after a time, discovered to his amazement that a neighbouring doctor was also visiting the patient. The latter had "gate-crashed" in unasked and was actually prescribing for the patient at the same time as the legitimate medical attendant, the timid patient apparently not daring to protest.

On the other hand a sanctimonious, not too competent practitioner in the nineties, non-plussed by delay in the second stage of labour, called the family round the bed, and said; "Art has done its best. Let us pray." In this case I think it will be allowed that the family were right in calling in another doctor who applied forceps, and all was well.

About etiquette among consultants I know little. There is free trade among consultants I hear, which I suppose means that patients can be sent to several physicians or consulting surgeons for the same complaint, but I never like doing so. Sometimes one is goaded into doing so by the intractable nature of the patients' illness and its chronicity, so that to infuse fresh life into the case, it seems justifiable to suggest another consultant always supposing that the latest consultant is not still concerned in the treatment, and getting reports.

Generally patients are sent by their doctors to consultants, and it is well not to let them suggest this before you do.

A shrewd old practitioner, Dr. Fowler, of Cirencester, who will be known and remembered by many old Bart.'s men, had a quick eye for incipient restlessness on a patient's part. The moment he detected it he would assume a serious air and call for a telegraph form, silencing the relatives' anxious enquiries, by say-

ing the case was taking a dangerous turn and he must have the advice of Sir Tumley Snuffin, thus disposing of any possible chance of the family wishing to have his opposition neighbour called in to consultation.

Patients usually leave the choice of consultant to their doctors but occasionally they adopt one of two courses, or both. They announce that they have decided to consult so and so, and will you write to him, which is quite agreeable and in accordance with etiquette, or they consult so and so without saying anything to the doctor, which puts the consultant into an awkward position. The best consultant always suggests writing to the doctor, and the less good type admits the patient into a nursing home and doesn't say a word or suggest saying a word to the doctor, who only hears of the affair at third hand by gossip. I can't imagine any man being offended by a patient wanting to see a consultant, but I know some men think they have sole proprietary rights in a patient and his complaints.

As for patients who consult quacks, it is better to smile indulgently rather than to enter into arguments with them; so long as they don't want you to write to or meet the quacks, what does it matter? Bone-setters are the worst, and the public love them and make them knights. They always find there is something "out of place," generally a vertebra, and it's best to receive the information with a bow, and soon after change the conversation.

If a new patient comes to you and you suspect he has been another doctor's patient, it is neces-

sary to satisfy yourself that he is not being treated now by the doctor, nor has been recently, for the same complaint. You can satisfy yourself on that score without cross-examining the patient, and if he has not been treated for some time there is no reason why you should not see him. In fact it is difficult to see how you can avoid doing so, and it's not necessary to write to the doctor to say you are seeing a patient whom you believe was once his, although you might mention it if you meet him. But neither etiquette nor ethics demand that you should.

As to "dumping" or setting up a practice without buying one, it would seem to be justifiable in a rapidly growing neighbourhood and even in a non-growing neighbourhood if the existing practitioner is notoriously slack or bad. But whether one buys a practice or partnership in the orthodox way, or just dumps oneself down and hopes for the best, etiquette certainly demands that one should call on the existing medical men, and this calling is practically a dead letter, except among the less commercial new-comers.

Personally I have never had anything but the most extreme courtesy and kindness from the consultant, and dealings with the heads of the profession constitute one of the most agreeable and inspiring parts of general practice.

"But come (you'll say) that's quite enough

Of this absurd disjointed stuff," which, however, may serve to provoke some reflection and some contradiction.

H. E. B.

## A VISIT TO BART'S

It has been suggested that, having enjoyed the hospitality of Bart's for some weeks, I might, perhaps, like to record some impressions of my visit.

"Enjoyed" is perhaps not quite the right word. I would have preferred "endured" as more truly describing my sensations, and I greatly doubt whether elderly gentlemen ever really enjoy parting with their prostate gland and all that it entails.

In my case the presentation of a chunk of granite said to have been found in my bladder has left me wondering vaguely whether other treasures may have been discovered but withheld from their rightful owner.

I observed a strange tendency on the part of Bart's guests to discuss in intimate detail subjects that would never be touched upon out-

side, and have heard a dissertation on the manipulation of the bedpan hold an audience enthralled, while an impassioned account of a faulty catheter had to be repeated to an overflow meeting.

It is only natural, I suppose, that invalids should each be obsessed with his own particular load of mischief and eager to talk it over with others, so that our conversation was invariably biological.

Poe's "Tales of Mystery and Imagination" are good enough in their way, but for stark realism I prefer the strange story of a floating kidney that vanished in the night, as told me in the twilight by the late proprietor.

Then there was the gastric ulcer that had defied the best brains of Hastings, but which had been successfully dealt with by the superior



brains of Bart's.

The man from the South Coast to whom it belonged was loud in his praises of the eminent surgeon who had performed the miracle, and this admiration I found was universal.

Or nearly—one case I DO remember of a disgruntled patient.

He was a youthful mariner suffering from a quinsy, whatever that may be, and occupied the bed next to me. It was, I think, on the second day of his stay that he informed us he possessed £23, that he was fed up with lying in bed, and intended to pick up a nice girl and have a good time at Charley Brown's.

His invitation to one of the nurses to share in the binge was turned down, and he and his quinsy departed, but the mention of £23 left the ward gasping and a severe case of bronchitis nearly choked.

Life in the ward ran smoothly and strictly according to an established time-table.

Shortly after midnight—6.0 a.m. to be exact—breakfast was served, to be followed immediately by an orgy of bottle parties and screen workers.

At 7.30, with the arrival of the day nurses, there would be much washing of torsos and bed making.

The making of beds in the home is a slow and painful process, but, in the hands of these experts, a matter of seconds.

Those of us who are sufficiently agile leap from our beds while the others are lifted gently as occasion requires.

At 10 a.m., like so many rays of sunshine, doctors and dressers appear and life begins in earnest.

Beds are screened off, and we are left guessing as to what goes on inside, but each day and in every way, as the late M. Coué would have it, each case is better and better.

It is about this time that a furtive individual with morning papers flits through the ward,



“THE BRAIN'S TRUST”



but, like the elusive Pimpernel, is not easy to catch, and seems more eager to escape unobserved than to sell his wares.

I had always imagined that a blood transfusion left the donor exhausted and on the danger list, and was pleasantly surprised to find that my next door neighbour's young wife, after parting with a pint of her life's blood, had gone on to the pictures.

The revels end as dinner is served—a meal that I always found appetising—and here let me say Cook gets full marks from me for her soups.

As in any well appointed West End club the afternoon is largely devoted to slumber.

A break for tea when a few favoured individuals achieve a boiled egg. These, we suspect, are the proud owners of a poultry farm, but most of us go eggless.

What is delicately termed back washing and bed making follow, and, as the evening shadows lengthen, a motley crowd of convalescent cripples gather round the gas fire constituting the Bowlby Ward Brains Trust.

At intervals during the day cascara cocktails and other liqueurs are brought round, and at last, with lights out at 8 p.m. the long day closes, and as I lie I recall once again what has been done for me, and I realise I owe old Bart's such a debt as I can never hope to repay.

I am not likely to forget the amazing knowledge and skill shown not only by a very great surgeon, but by his gifted helpers and the kindness, gentleness and unvarying patience shown towards a particularly unpleasant and sometimes impatient patient.

WILL OWEN.

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## TRACING BIBLIOGRAPHICAL INFORMATION

By JOHN L. THORNTON, *Librarian*

(Now serving in H.M. Forces).

Most medical men during some period of their careers desire to embark upon research. Perhaps during their student years, or after qualification, a certain subject attracts them, and they decide to pursue it either as a full time study or as a sideline. If it is developed into research for future publication it is essential that it be conducted on certain lines, and completed in a scientific manner. Firstly, before one can conduct research on any subject one must discover what has already been accomplished in that field, and it is here that bibliographical research begins. Perhaps an interesting article has attracted one, and the references provided guide one to further reading. Make notes of these, preferably on cards, and arrange them either by authors or chronologically. If it is then required to compile a fuller bibliography before consulting the actual articles, it is necessary to use the printed bibliographies and catalogues, or special monographs, if these possess good bibliographies. Two such books are called to mind, namely, Lattes' *Individuality of the blood*, 1932 and Browning's *The vitamins*, 1931, which contain approximately 2,500 and 4,000 references respectively. Those likely to contain required material are listed on cards, and arranged as above. Printed bibliographies may be in subject or dictionary form, the latter combining author and subject headings, and two invaluable periodical publications of this type exist in the *Index Catalogue of the Army*

*Medical Library*, and the *Quarterly Cumulative Index Medicus*. The *Index Catalogue* can only be used for older material, as one volume covering only a section of the alphabet is issued annually, but the *Index Medicus* is maintained up to date.

Special bibliographies exist for many subjects in the form of abstracting periodicals, which include the *Annual Review of Biochemistry*, *Biological Abstracts*, *British Chemical and Physiological Abstracts*, *Nutrition Abstracts and Reviews*, and *International Abstracts of Surgery* which is issued as a supplement to *Surgery Gynecology and Obstetrics*, to name only a few. Furthermore, many other periodicals contain sections devoted to abstracts of articles in other journals, these being most useful in enabling one to keep abreast of modern research.

From these sources extensive lists of references can be compiled, and it is then necessary to trace the items. Our own Library contains a good selection of the more important medical and surgical periodicals, and from catalogues of other libraries it is possible to inform enquirers where sets of other journals are available, and whether or not the libraries housing them are willing to give non-members access to literature.

If references are recorded on cards, annotations can be included as the articles are consulted, and it is also very necessary carefully to check the actual reference. Ensure that com-

plete bibliographical details are recorded, and never trust a reference until you have checked it with the original. In the case of references to articles in journals, author, title of paper, title of periodical, volume, date and pagination are essential, while details of books should include author (with initials or christian names), title, edition, place of publication, publisher if necessary, and date of publication.

When writing an article or book, ensure that all references are correct as printed, and that the details of each reference are recorded in the same order. When preparing a manuscript for the periodical press, consult the note to contributors for information on the arrangement to be adopted for references to avoid their being altered, and most probably rendered incorrect. Certain periodicals require the name of the author to be followed by the date of

publication in round brackets, while others place this information at the end of the reference. Adopt a standard method for private use, and modify it to suit the requirements of the publisher, when using the references for articles. Finally, be accurate in recording details of papers and books, for it will save yourself and others much trouble in tracing them. Consider this recording of previous work as a most important part of your research, for the compilation of an extensive, accurate and valuable bibliography lays the very foundation of your future studies, and when these are recorded in print, have no fear should the following test be applied to your work. Judge the state of an author's mind by the arrangement of his references. One authority mentioned that if this was found inadequate, he never bothered to read the text!

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## NIGHT TRAIN TO GLASGOW

I wonder how many medical students have been asked, quite spontaneously, "You're a doctor, aren't you?" and how many, especially such as have passed one or two parts of their finals, reply at once, "No, I am only a medical student." I have never claimed to possess much in the way of clinical presence, or even that I looked interesting, but the fact remains that this very question has been put to me by complete strangers on several occasions. My own reply is usually rather non-committal and designed to leave the questioner with the idea that, while not exactly what you might call a doctor, I am at least in the profession, somewhere below a specialist and somewhere above a lab. boy.

It always seems to occur on the least likely occasions. Once, a man sitting opposite to me in a restaurant car said he knew I was a doctor because of my eyes; but he didn't explain which of their peculiarities led him to that conclusion. On another occasion a woman in a shop where I was buying a second-hand walking stick said she could see I was a doctor and what ought she to do about an awful pain in her ankle.

On the present occasion I was lying on the floor of the guard's van in the 9.15 p.m. from Euston. There were twenty-six people in the van, the usual collection of sailors, soldiers and airmen, with the Glasgow accent predominant. The only anomalous feature was that everyone

seemed to be more or less sober.

Nearby a Glasgow-Irish soldier was making himself comfortable for the night. It appeared that a wire rack which the railway authorities had seen fit to screw to the side of the coach was interfering with his comfort and with the admirable directness of his race he proceeded to tear it down by main force. I was trying to read and the commotion disturbed me, so pulling a screwdriver from my rucksack, I offered it to him, politely suggesting that the more orthodox procedure of removing the screws would yield a tidier result with much less trouble. To my surprise he accepted gracefully and the job was soon finished.

Up to this point I cannot see how by word or deed I had given any clue to my occupation, past or future, but we had hardly settled down again when my other neighbour on the floor came out with the old question, "You're a doctor, aren't you?" I embarked on my ambiguous reply, but he appeared satisfied and started to tell me about his knee. It was a long and uninteresting story and I failed to make any diagnosis, but it kept us going from Rugby to Crewe. As he prattled, I reflected on the fiasco which might be enacted if a doctor were really needed and this man championed me as such. There might be an accident, an air raid, or somebody might faint.

I insist that it was the cold, and not these reflections that made me decide to go for a

walk along the corridor. It was much colder in the corridor, but the chorus of oaths which had arisen as I picked my way between the sleeping figures on the van floor dissuaded me from returning to my place, and I had a vague idea that I might find a seat.

I tried several more corridors and finally met an officer who said his compartment was too hot. We talked for a while about how tastes differ and then I left him abruptly when he admitted that there was a vacant seat in his compartment. It was a very hot compartment; the windows were up, the blinds down and the heater full on, and I sat back and basked in it. Opposite me were two rather hypertensive business men wearing heavy ulsters. Just before I fell asleep I remember thinking that they conceivably might get too hot.

The train had progressed several hundred miles before I was awakened by a further commotion. Somebody was talking in that Glasgow accent again, so my first impression on opening my eyes was that my rack-wrecking friend had transferred his field of activities and I sleepily reached for my screwdriver. As I absorbed the scene, however, my heart leapt. It had happened, somebody had failed.

It was one of the ulster-clad business men

and the supposed rack-wrecker was his companion reaching up to get some brandy out of his bag. The patient recovered quickly and peace would have prevailed but for my pride. Had I not, but a few hours past, been mistaken for a doctor? Had I not devoted years to medical study? On such an occasion the public should reap the benefit of my labours.

"Cerebral ischaemia," I thought. "He ought to have his head down." A small timid voice, faintly resembling my own, spoke out, "Shouldn't he be lying down?" They stopped the brandy flushing and considered it. They decided it was good advice and there was a general reshuffle. He was a small man and easily accommodated on two seats, which meant that one less seat was available.

Ten minutes later out in the cold corridor, watching the sad, grey streaks of dawn starting over the Ayrshire hills, I was trying to work out the moral of all this. An airman was standing hugging himself. "Bloody murder," he remarked, "it's hellish cold. Travelling's a ruddy bore."

I agreed about the cold, but "boring"—never. We were still arguing the point when the train drew up in Glasgow.

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"SURGICAL CASE," R. W. Raven, Major, R.A.M.C. (Arnold, 10s. 6d.)

This short volume is clearly intended for the student, who must not be misled by the sub-title—"A Handbook of pre- and post-operative treatment." Except for two pages, on which are enumerated post-anesthetic complications, the first 115 pages are in great part devoted to a general survey of elementary pathology. But two chapters presenting the simple facts about radiotherapy and physiotherapy stand out from the rest in their value to the student: their value would have been enhanced if the author had intimated the conditions for which these forms of therapy are applicable. The chapters comprising the next 116 pages are all concerned with the care of the pre- and post-operative patient. In the final pages an account of laboratory and radiological investigations is to be found.

Though the book is slender its subject matter cannot be grasped quickly, for it is written after the style of textbooks, which precludes either rapid or continuous reading. Further to this there is a tendency to dogma; a discursive attitude would have been more enlightening to the student and would also have provided more palatable reading. The chapter on burns may be taken as a fair example. After being given an outmoded classification of the degrees of burns, the reader is informed of some of the many methods by which they may be treated, but is given no idea of the benefits or of the disadvantages accruing from any of the methods. He is left to choose his fare without knowledge nor fear of the consequences.

As a book on elementary surgical knowledge this may be useful to the student; but as a book on pre- and post-operative care it is disappointing.

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## DICKENSIAN—SOLUTION

By Peter Quince

ACROSS

1. Kutankumagen (*Mudfog Assn.*); 12. Ish; 14. Null; 16. (No) Go; 17. Nandy (*Dorritt xiii*); 20. Phil(kins) (*Dombey i*); 21 rev. Caul (*Copperfield i*); 22 rev. Specks (*Uncomm.Trav. xii*); 23. Jo(ram) (*Copperfield ix*); 25 rev. Pe(epy) (*Bleak Hse. xiv*); 26. GK; 27. Losberne (*O. Twist xxxvi*); 31. Nige(ria); 32 rev.

Leoni(ne); 37 rev. St(ellion); 39 rev. Man(ette) (*Two Cities vi*); 40. Lews(ome) (*Chuzzlewit xxv*); 42 rev. Eum(enide); 47 rev. Hop(kins) (*Pickwick xxxii*); 48. Slammer (*Pickwick ii*); 51. Woodcourt (*Bleak Hse. xi*); 52 rev. Flo(pson) (*Gt. Expectms. xxii*).



## DOWN

2. U.S.A. (*Chuzzlewit xxxiv*); 4 rev. 3. Bed-bath (*Chuzzlewit xxix*); 7. Union (Hamlet, 5, ii); 8 rev. Lum(bey) (*Nickleby xxxv*); 9. Allen (*Pickwick xxx*); 10 rev. Haggage (*Dorrit vi*); 11. Nockemort (*Pickwick xxxviii*); 15. Lupin (*Chuzzlewit lii*); 24. Jet; 28. (All) One; 29

rev. Wos(ky); (*Sks. by Boz*); 30. Red(law) (*Haunted Man*); 33 rev. Dose (*Dorrit iv*); 34 rev. Chil(lip) (*Copperfield i*); 38. (Li)Tmus; 47. Po(ncho); 48. So (Sorceror, 2); 49. Lu(te).

## THE GHANDI FAST

By JOSIAH OLDFIELD

Very few of the fasts that men have carried out have aroused so much world-wide interest as what may be called the "Gandhi Fast."

The picture of the tiny little pathetic shrivelled old man standing up before an imperial giant and saying: "I defy you, I am prepared to suffer fines or imprisonment. I am ready to sell my life by daily inches rather than yield a tittle of my position. I threaten you that I will fast up to my capacity."

Nowadays, when for the last fifty years, men have been shouting at each other to "eat more of this, drink more of that," and have consumed larger and larger amounts of every kind of food and drink, there has grown up the conviction that in order to live men must go on and on and on with their eating and drinking.

To miss a meal is a sign of illness, to think of a fast is like looking over the edge of an unknown precipice.

So the mite Gandhi sitting up and threatening to fast if he cannot have his own way tickled and thrilled the world, and even for some people dwarfed the war news, with its recordings of untold numbers of Jews dying of hunger or slowly agonising in concentration camps, and thousands broken and blasted and maimed and blotted out in colossal battles.

Little Gandhi filled the picture for a few days largely owing to the love of the sensational and, not infrequently, of the silly.

From the scientific and medical point of view there was nothing new in the Gandhi fast. From the legal point of view, no fresh legal problem was involved.

Since, however, the minds of millions have been turned to the problem of fasting, let us consider it quite apart from any political question.

Some years ago, there was a spectacular fasting stunt and people in crowds paid to see a man like Succi, who, day after day, was paraded round and was body-guarded to pre-

vent him taking any food surreptitiously, and who gave talks about his sensations and was shaken by the hand for hours every day.

People gaped and wondered and half of them were intrigued and the other half wondered where the trick was.

Then there was the Maltese Levanzin who submitted himself to the Nutritional Laboratory of Boston for a 31 days' fast from everything but water and underwent most careful investigations as to the effect of fasting upon bodily functions.

When we examine Gandhi's case we find in the first place that he did not really fast at all, and that secondly he only threatened to fast up to "capacity," thus retaining the right to eat whenever he decided that food was necessary.

Gandhi did not "fast," he only abstained from proteins and fats.

As long as a man has a continual supply of carbohydrates and water—although the amount may be very small—he cannot be said to fast.

While fasting means complete abstinence from food, it is not generally understood to exclude water.

Without a little water a fasting man cannot maintain his life, although I know of no observations that have been made to determine how long a "hibernating" man, deprived of water, can live, nor am I sure that all hibernating animals are entirely deprived of all water during their period of hibernation.

Gandhi's was a case of "abstinence" rather than a case of fasting.

It might, perhaps, be rightly described as a case of "modified fasting."

In cases of fasting, the body uses up first of all the stores of food that are already in the alimentary canal and draws upon any fluids that are being retained in the body cavities, and those that are in excess of need in any overfilled tissues.

Then gradually the stores of fat in the body are used up, but since fat can only be fully

oxidised by being used up in connection with some carbohydrates, the glycogen stored in the body is gradually drawn upon.

So long as there are stores of fat and glycogen, the body energy can continue and health be retained, while there is a slow but steady loss of weight.

The chief loss of weight is caused by loss of water from the body, and apart from that, the actual body weight is very slowly and still more slowly reduced.

Fasting is generally accompanied by a reduced output of energy, and in hibernating animals the energy output is greatly reduced and the loss of weight is extremely gradual.

In Levanzin's case, the total loss of weight during 31 days was from 60.6 kilos to 47.4 kilos, that is, only 21.9.

In addition to the using up of body fat and body glycogen, there is also protein metabolism and for this muscle tissue is used.

So long, however, as there is enough fat and glycogen to supply the body energy, there is very little drain on the muscle protein.

In Levanzin's case only some 7 grammes of body protein was metabolized for the first few days and then the protein was called upon, because the glycogen was getting low and the body had to transform protein into carbohydrate.

This is the point at which the danger in fasting may show itself.

If there is no carbohydrate, either from food or from stored glycogen, available then some carbohydrate has to be manufactured in the body from protein.

This causes an increased loss of precious protein.

Furthermore, if the body is not able to obtain by this manufacture, sufficient for the daily needs, then either the oxygenation of the fat will cease or will be incompletely carried out.

If it ceases, then body energy ceases, and just as the car quietly runs down and stops when

petrol runs out, so will the body machine run down and gentle death will supervene if oxygenation ceases.

On the other hand, if the oxygenation does not actually cease but is only reduced, then we get the body poisoned, by acetone being formed.

So the body is in this dilemma.

If the body has no more glycogen and if it cannot manufacture enough carbohydrate from the protein, then it will either die of loss of energy, or die of acetone poisoning.

If, however, the pituitary gland is efficient it rises to the emergency and, as it does in hibernating animals, it slows down also, in the fasting man, all metabolism.

The body then begins to function at a lower and lower level.

The body manufactures from the protein enough carbohydrate in the form of glucose to allow for the complete oxygenation of the fat that is needed to supply the very little energy that is requisite to keep the body engine just "ticking over."

At this low level health is maintained, the loss of weight becomes very little, and acetones poisons are not formed and the body continues just to function with very little energy, for quite a long period.

In Gandhi's case there was no such danger, because Gandhi allowed himself a supply of fruit juice, and the occasional addition of sugar or honey, so that he neither risked death by cessation of energy-production, nor death by acetone poisoning.

The awestruck world watched wonderingly at what was only a "trick fast," *i.e.*, it possessed the facade and appearance of a fast, but one which was shorn of its dangers.

It reminded me of the snake charmer who does his thrilling and dangerous act with deadly cobras.

The public watch with tense held breathing and with an awed anxiety, but did they but know that the cobras' fangs had been extracted, the act would fall very flat!

## At HILL END

At the elections recently held at Hill End the following positions were filled:—

To the Students' Union:

G. E. Bond, A. E. Fyfe.

To the Hill End Bart.'s Club:

G. E. Bond, I. A. W. Peck.

Early in the month Dr. Geoffrey Evans gave us a most interesting talk entitled "A Contribution to the Study of Human Nature." He

started by saying that the medical man was most concerned with Philosophy, yet he was taught none during his long training; this discussion was to be on his observations throughout his 56 years of crowded experience. From the talk which followed this introduction there could be no doubt that Dr. Evans had had a life of "crowded experience"; it is only possible for me to pick out a few points here and there.

He spoke of Jeans's theories of the origin of the universe and then of Darwin's theory of the origin of the Human Race. He believed that there is an essential difference between man and the animals and that man's language does not correspond to the noises of animals.

He agreed with Jung that the Human Race has a common origin and therefore an inherited tendency to develop along certain lines. This is proved by the fact that certain symbols are found in apparently unconnected parts of the world. He did not, however, discuss the possibility that there could be a diffusion of ideas and symbols from one community to another. He maintained that there is a basic nature common to every man; it is made up of three factors, a Self-preservative, a Self-creative, a Self-destructive; that there is a conflict between the first two and the third, and that the balance must be maintained. In disease the instinct of self-preservation is lowered by fear, and also by self-pity and self-indulgence. This danger will be minimised if the patient's life is centred on some object outside the Self. A common observation is that soon after a man retires from work he dies, this is because he has lost his "Object." It is the doctor's duty to keep man at work so that he does not become self-centred. I wish that Dr. Evans had had time to enlarge upon this point as it is of the utmost importance. A doctor should be certain that a dominant sentiment is present in the patient's life before he even writes the letters P.R.N. of the Blue Board. Without it all the drugs will be of as much avail as a textbook to a Problem Child.

Dr. Evans then said a few words on the

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A concert of the Passion Music from Handel's "Messiah" was given in the Reception Hall on Thursday, March 18th. Once more an excellent performance was forthcoming from the society, but one very important part of choral singing was noticeable largely by its absence. It is essential for singers to hold copies well up for two reasons: the first, so that the tone should be at its best and the second, and perhaps more important, so that they can watch the conductor the more easily. In one or two of the choral numbers it was a little doubtful whether the choir was leading the conductor or vice versa.

The choir itself was reasonably well balanced but the acoustics of the hall are notoriously appalling and that perhaps was why the words were not always recognisable. The solos were very pleasant, easy to listen to and well within the range of the singers; the accompaniment

difference in the natures of men and women. A man's life is centred on things and ideals, while a woman's is on Being, she tends to analyse situations and people. He advised us never to allow a woman to talk to us about ourselves, or we would run the risk of losing control of the patient, or fall into the even more ridiculous situation of being controlled by her. To end his most interesting talk Dr. Evans shone the light of his experience into the future. He observed that at the present moment the Instinct of Destruction is dominant in the world and unless we see that it is displaced by the Creative, no amount of politics will prevent another war following close on the heels of this one.

The Rugger season here has been exceedingly good. We won all the matches played at home, and of the away matches we lost only two. Both of these were fully avenged later on the return home match. The other day we beat the Housemen at seven-a-sides, they had the most marked disadvantage of being very out of training. In spite of his rosy morning smile a doctor's life is not a healthy one. However, the result of this match pleased us a lot, as it proved that passing the Finals does not in fact make a better man of you. As will be seen from the report on the intra-hospital seven-a-sides, our teams did not distinguish themselves. As a matter of fact the only match we won was that against the hockey side. It may be recalled by anyone who has read previous Hill End Notes that the last time the Rugger team was beaten it was by the newly formed Soccer team.

F. J. C.

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was competent.

A second performance was given in the Chapel on the Sunday following. On this occasion we were most fortunate in having Dr. Tysoe, the Abbey Organist, who so kindly came along to play for us. Of his playing I need say no more than that he amply fulfilled my high expectations.

Neither the soloists nor the choir were on the top of their form, appearing to be overwhelmed, whether by the atmosphere of the chapel or by the august presence of Dr. Tysoe, it is difficult to say. It is unfortunate that the contralto considered herself unable to finish her solo, and that the soprano was in parts so very flat. The choir, be it to their credit, managed to sing the Halleluiahs Chorus as though they enjoyed doing so, in spite of the organ and their conductor, thereby illustrating the remarkable effect obtained by all three



proceeding at different speeds.

It is inevitable that even the uninitiated will compare such well-known music with a performance by experienced singers, but in spite of this both performances were well received,

and enjoyed. I hope I do not appear to have been a little hard in my criticism of these performances, but I deemed them worthy of criticism rather than empty praise.

## CORRESPONDENCE

To the Editor, St. Bartholomew's Hospital Journal  
Sir,

It would be far better to admit women to St. Bartholomew's than keep on saturating the country with women doctors from Scotland and Eire.

Yours faithfully,

W. HUNT.

"Ashmount,"  
Carlton,

Nottingham.

To the Editor, St. Bartholomew's Hospital Journal  
Dear Sir,

I wonder whether any of your readers can furnish an explanation to the following problem; it undoubtedly has a simple explanation, but enquiries in various directions have so far failed to elucidate one.

Facing page 60 in the late Sir D'Arcy Power's book, "A Short History of St. Bartholomew's Hospital," there is reproduced the Seal of the Medical College. Above the date 1123 is depicted the Smithfield Gate as it stands to-day, and above the date 1662 there is drawn a gate of similar appearance but differing decidedly in details. Rising on each side to the same height there are house fronts,

and this fact leads one to suppose, at first sight, that this drawing represents the gate as it originally stood, for the original gate was similarly "hemmed in" on either side by high buildings. These were demolished during the last century, certainly later than 1801, for I possess a contemporary print showing these same houses. The interesting point is that this print also shows the face of the gate in precisely its present form.

What then is the explanation? Does the second drawing represent the gate as it appeared at some time in the last century, does it portray one of the other hospital gates since swept away, or could it, for some unknown reason, show a gate to some other institution designed by the same architect (James Gibb)?

The fact that this Seal was designed as late as 1921, should render an explanation forthcoming. I should be most interested to hear one.

I am, Sir,

Yours faithfully,

JEFFERY SPRY LEVERTON.

Woodmanstree, Surrey.

April 8th, 1943.

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## At CAMBRIDGE

At the beginning of December, 1942, a meeting was held in Queen's with the object of forming a Musical Society in Cambridge, it having been decided that in addition to sport the Students' Union ought to sponsor the cultural activities of the students (sounds rather hackneyed and communistic-ally inclined, but maybe it wasn't intended to put forward an inverted sense of snobbery). But, nevertheless, the essential idea, in contradistinction to the idea of cultural development (please note, Alan Tois) was very popular, and at the meeting a Musical Society was formed, which was to cater for all types of musical taste. As a nucleus the society formed a classical branch and a Jazz Club, and within this basic framework the following officers were elected.

President, K. M. Backhouse.  
Secretary for Classics, J. E. R. Dixon.  
Secretary for Jazz, E. G. Goff.

It was decided that the initial activities of the Society should be of a gramophone programme nature, but it was suggested that later a chorus should be formed and that the Musical Society should also arrange Sunday concerts, and, if possible, also form instrumental ensembles.

At the end of the term, therefore, two programmes were given on gramophone records to the classical section, the first by J. E. R. Dixon and P. Bradfield, and the second with explanatory notes on the works played, by K. M. Backhouse. The Jazz Club also heard a programme on the "Growth of Jazz," by D. E. Friedman.

Last term a similar system was continued, but owing to lack of a gramophone "pick-up" we were

very much handicapped. On the classical side, however, weekly programmes were given by the President, and then eventually about half-way through term a Bart's man was found with sufficient courage to present a programme. This was T. R. Bomonji, and then further programmes were given by H. D. Yanner and B. Jaslowitz.

The Jazz Club had a programme on "Bix" at the beginning of term, but then owing to the loss of the secretary a break was experienced. D. E. Friedman, however, took over and regular programmes were started again with a programme of "Boogie-Woogie," given by P. M. Goodrich.

In addition, last term the Bart's Male Voice Chorus (Cantab) began its career (very gently I'm afraid, but nevertheless it *did* begin).

The idea of doing a musical concert had to be abandoned, on account of lack of support on the performance side. In fact, in addition to a few pianists, a violinist and a flautist the preclinicals seem completely devoid of virtuosos in any shape, kind, or degree. Even the conductor's baton quivered at the thought of a public performance, whilst a shifty look became common in the college.

But having dispatched the President and several stalwarts to Hill End, things may begin to happen this coming term! At least we shall look forward once again hearing "Tiger Rag," Bing Crosby, Dinah Shore, and maybe even the L.P.O. resounding from a congestion of punts, the gay summer dresses of Homerton, the River Cam, and Bart's striped blazers and scarves.

K. M. B.

## SPORTS NEWS

### RUGGER

R. L. Hall is to be congratulated on playing for England in three of this season's services internationals.

*v. Middlesex Hospital. Away. March 20th. Lost 11-6.*

A most depressing performance—the forwards were lamentable on several occasions, they lost the ball after Mann had hooked it, they possibly considered that as the outsides could do little with the

ball the opposition might as well have it. Our first score came when Stephens followed a loose kick and beat their full back for the touchdown. Hawkes failed to convert. Early in the second half our play improved, and Davey at last used his speed to score far out, giving us a one point lead. Having achieved this the side lapsed back into coma and let them score twice.

*v. Coventry. Home. Lost 11-5.*

Coventry came down to Chislehurst with the impressive record of 23 consecutive wins, and though they made it 24 at our expense, nevertheless they had to work harder than in any game this season. To meet such redoubtable opponents we fielded a modified team which acquitted itself very well indeed. They were somewhat taken aback by our initial attacks, and but for a little bad luck we should have scored twice. Territorially we had the better of the first half; the only score came when their left wing forced himself over for an unconverted try.

Early in the second half Williams broke away. Wigglesworth and Stephens backed him up well, and the latter scored under the posts, Hawkes converting. From then on the game became rather tense, the referee doing his best to convert the game into a fight. A very unwise loose pass on our line gave them another unconverted try and a one point lead. At this point the weight and experience of their forwards began to tell, and despite innumerable free

kicks against them they kept us in our half. Just on time their fly half and right wing combined well and the latter ran magnificently to score a try, which they converted.

*Team.*—Gibson; Davey, Williams, Stephen, Jones; Hawkes, Stephen; Wood, Mann, Dew, Anderson, Stephens, Ross, Wigglesworth, Corbett.

*Hospital. 7 a side.*

In the first round we met King's, and after a shaky start eventually won 10-0. For the second year in succession we met St. Mary's, the ultimate winners in the second round. Our defence was very good, but unhappily we were defending most of the time and they scored twice. An outstanding incident was when Corbett ran some 40 yards, but exhaustion and Kemp brought him down when in sight of home. As last year, our trouble seemed to be complete absence of practice.

*Team.*—Davey, Jukes, Hawkes, Stephen, Corbett, Jones, Stephens.

## ASSOCIATION FOOTBALL

With the conclusion of the Lent term, we are now able to look back, with great pride, at a successful football season; and each man in the club, whether he be of the 1st or 2nd XI., is to be congratulated on putting up a very fine show, and thanked sincerely for turning out on Wednesday and Saturday afternoons, often in the most unpleasant conditions, with the possibility of finding that, on reaching the ground, the game has been scratched.

Although having suffered greatly from injuries, and having had K. A. McCluskey and H. J. Burns called on several occasions by the University, we can proudly say that we ourselves were never responsible for scratching a match.

Our record in the Cambridge Inter-Collegiate League, in which we were the runners-up, definitely does us credit.

Plyd.	W.	D.	L.	Goals		Pnts.	Position
				For	Agst.		
14	10	1	3	47	21	21	2nd

In the Cambridge Cup, however, we were unfortunately beaten in the first round. But we pick no bones about it, being overplayed by a better team

whose combination, especially in the forward line, was definitely superior to that of ours. Nevertheless, had we had our best team out there might have been a very different story.

During the latter half of the season, we arranged matches with R.A.F. and Army teams stationed around Cambridge, and most of them could boast a really strong team, thus providing very fierce and enjoyable games.

Our complete club record at the finish:—

Plyd.	W.	D.	L.	Goals For.	Against.
23	13	1	9	73	63

Of the 73 goals scored, K. A. McCluskey must be congratulated on scoring 25 of them, the next contestant for the honour of leading goal-scorer being our able captain, M. K. Mangor with 14. We must thank our landlords, Queen's College, for allowing us to use their ground every Wednesday, thus enabling us to play home as well as away matches.

Signed P. M. GOODRICH,

Hon. Secretary,  
St. Bart.'s Hospital A.F.C.

## HOCKEY CLUB

*v. Cheam. Saturday, February 13th.*

Right from the start we realised that we had some capable forwards opposing us, but our backs forestalled their initial run, and gave our forwards an open field to get away and P. C. Mark scored.

The rest of the game was very even with a great deal of fast play, and two well-managed corners in our circle. P. C. Mark scored twice more with the close co-operation of the other forwards, and we ended a fast and keen match with a score of three each.

*v. King's College Hospital, Saturday, March 13th. Won 3-1.*

K.C.H. ground at Denmark Hill must surely be the most primitive bit of landscape south of the Moor of Rannock, and while the hazards with which it is strewn add greatly to the interest of the game, they are not without effect upon the play.

The difficulties of the terrain seemed to affect our forwards less than our backs, and we started attack-

ing at once. Before half-time, Mark had scored after tricking the opposing left back with particular cunning, and Fyfe had brought our score to 2 by a lightning raid from centre half.

In the second half we were playing uphill with the sun in our eyes, so our defence had a great deal more to do. Our deputy goalkeeper, Sugden (who wears cement boots) kicked valiantly, but by a skilful piece of dribbling the King's centre forward passed each member of our defence in turn and scored. A rather untidy goal near the end made final score 3-1, giving us our seventh successive victory.

The weather was perfect, and the evening was amiably concluded at "The Fox (very much) under the Hill."

*Team.*—Sugden; Lucas, McIlroy; Buckley, Fyfe, Copestake; Giles, Andrews, Mark, Anderson, Bannerman.

## LONDON M.B.

*Honours—*

Campion, C. Distinguished in Obstetrics and Gynaecology.

*Pass—*

Ismay, D. G.  
Purcell, S. D.  
Wells, B. G.  
Jarratt, G.  
Roth, A.

Jones, A. E.  
Shah, J.  
McLaughlin, H. E.  
Vickery, K. O. A.

Castleden, L. S.  
Durham, P. D. A.  
Moffat, D. B.  
Street, D. F.

Conway, M.  
MacKenzie, W.  
Reese, A. J. M.

*Part II.*

Brennan, E.  
Reese, A. J. M.  
Morgan, L. J.  
Spencer-Phillips, P. J.

Philpott, M. G.  
Ramsay, G. S.  
Watkinson, G.

*Part III.*

Bromfield, F. B.  
McNeill, K. A.  
Zibbli, J. H. S.  
Eley, A. J.  
Ramsay, G. S.

Hanbury, W. J.  
Shaw, R. E.  
Levy, A. M.  
Thomas, M. V. P.

## SUPPLEMENTARY PASS LIST

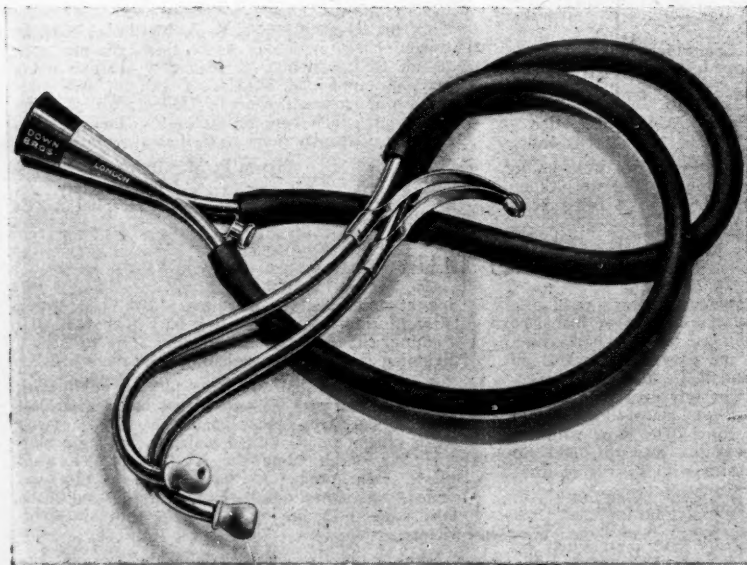
*Part I.*

Anderson, A. R.  
Davies, T. D. L.  
McNeill, K. A.  
Shirazi, M. R.

Chambers, R. M.  
Helm, H. G.  
Mortimer, K. E.  
Thomson, W. G.

## BIRTHS

PHILLIPS.—On April 13th, 1943, at Lytham Hospital, Lytham, Lancs., to Sheila (née Redding) and Basil (S/Ldr. R.A.F.V.R.), of The Willows Cottage, Clifton Drive, Lytham—a son.



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